SECTION 1000

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1000 INTRODUCTION

1100 SCOPE

1110 Recipients of AFDC or SSI
1120 Assistance Units
1130 Referrals
1131 Referral to Child and Adult Protective Unit
1132 Referral to Fraud Investigation Unit
1133 Outreach
1140 Confidentiality
1150 Record Retention
1160 Out-of-State Coverage
1170 Replacement of Medical Identification Cards
1180 Fair Hearing
1181 Fair Hearings
1182 Right to Judicial Review

1200 BASIC ELIGIBILITY REQUIREMENTS

1210 Citizenship
1210.1 Retroactive Coverage Only
1210.2 Reserved
1210.3 Documentation and Verification
1220 Residence
1221 Individual in a Medical Institution
1230 Social Security Numbers
1231 Retroactive Coverage
1240 Assignment of Rights to Medical Payments (Referral to TPL)
1240.1 Assignment of Support Rights
1241 Cooperation in Obtaining Medical Support from the Non-Custodial Legal Parent and Establishing Paternity
1242 Good Cause
1250 Sanctions
1260 Individuals Residing in Public Institutions or Psychiatric Facilities
1270 Other Benefits

1300 APPLICATION PROCESS

Rev. 3/99
#175A

1400 CLIENT AND AGENCY RESPONSIBILITIES

1410 Verification of Eligibility Factors
1420 Reporting Responsibilities
1430 Processing Standards
1431 45-Day Processing Standard
1432 10-Day Processing Standard
1433 Adjustment of Temporary Coverage
1440 Notices
1441 Notice of Eligibility or Ineligibility
1442 Adverse Action Period

1500 ELIGIBILITY PERIODS

1510 Categorically Needy Eligibility Periods
1511 Changes Within the Categorically Needy Eligibility Period
1520 Medically Needy Eligibility Periods
1521 Changes Within the Medically Needy Eligibility Period
1530 Retroactive Period
1540 Recalls
1550 Reviews

Rev. 3/99
#172A

INTRODUCTION

1000 The Maine Department of Human Services is responsible for administering the Maine Medical Assistance Program in compliance with federal and State statutes and administrative policies. This Agency establishes and applies written policies and procedures for taking applications and determining eligibility for assistance that are consistent with the objectives of the Program. It also respects the rights of individuals under the United States Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act and all other relevant provisions of federal and State laws which do not result in practices that violate the individual's privacy or personal dignity. The Agency further holds any policies or procedures developed at the regional level to be consistent.

Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act state that no person shall be excluded from participation, be denied benefits, or be subjected to discrimination on the grounds of race, color, national origin, sex, gender orientation, religion or handicap under any program or activity receiving federal financial assistance. Therefore, the programs of the Agency, like every program or activity receiving financial assistance from the federal Department of Health and Human Services, must be operated in compliance with the law.

In accordance with the Americans with Disabilities Act, no qualified individual with a disability will, by reason of such disability, be excluded from participation or be denied the benefits of the services, programs or activities of the Maine Department of Human Services, or be subjected to discrimination by the Maine Department of Human Services.

1100 SCOPE

Medical Assistance Programs

Medical Assistance provides payment of medical services for eligible individuals and families under one of three major programs:

Categorically Needy Program (Medicaid)

This program includes those individuals who qualify for medical coverage without having to meet a deductible or "spend down".

Medically Needy Program (Medicaid)

This program includes those individuals whose income or assets are too high to qualify as Categorically Needy. They qualify for medical coverage after meeting a deductible or "spend down" .

Cub Care (Child Health Insurance Program)

This program provides Medical coverage to individuals under the age of 19 for which a premium payment is required. It is funded under Title XXI, Child's Health Insurance Program (CHIP).

1110 RECIPIENTS OF TANF, SSI OR STATE SUPPLEMENT

Aged, blind or disabled individuals and couples who are recipients of SSI or the State Supplement to SSI are automatically covered as Categorically Needy unless they refuse to assign their rights to payments for medical care. A separate application for Medical Assistance (including coverage for any Home Based Waiver program) is not needed for these groups.

If nursing home coverage is requested, eligibility criteria specific to this coverage needs to be examined. An application form needs to be filed if there is not a current one filed with the Department.

TANF applicants may be eligible for Medical Assistance if they meet eligibility criteria. A separate application for Medical Assistance is not needed.

1110 cont.

When recipients of TANF, SSI and/or State Supplement lose their eligibility for a payment, their automatic medical coverage is not terminated. Such recipients' eligibility for continued Medical Assistance coverage must be reviewed. (See Section 1550.)

1120 ASSISTANCE UNITS

I. An assistance unit is that individual (or group of people) who is receiving or potentially eligible to receive Medical Assistance. Persons are covered for Medical Assistance as an assistance unit because they meet the eligibility criteria of a particular coverage group.

II. An individual or family may meet the eligibility criteria for coverage in more than one assistance unit. Such persons should be covered in the assistance unit which is the most beneficial to the applicant in terms of timeliness of the decision, whether other family members can be covered and services covered. When options affect which family members who want coverage will be covered, the individual must be informed of the coverage options and given the opportunity to choose which coverage is preferred.

EXAMPLES:

1. In a family with a disabled parent, the disabled parent could be covered as SSI-related (based on disability) or included with the rest of the family as Family-related. Family-related coverage provides the quickest decision.

2. In a family in which a child has countable income which would affect the eligibility of other family members, the child may be removed from the assistance unit. The child and any responsible relatives may then become members of a separate assistance unit. The responsible relative is also a member of the original assistance unit.

3. The family consists of a parent and two children. One of the children receives two hundred dollars a month in child support. The other child has no income. The parent's earned income, in combination with the child support puts the assistance unit of the parent and the two children into a large deductible. Therefore, the parent and one child can be an assistance unit with only the parent's income considered. The parent and the other child can be considered as another assistance unit with the parent's income and the child support counted as income.

III. When SSI or State Supplement payments are received by some family members, that member is not included in the assistance unit. The SSI payment is excluded income. Only income allocated by SSI budgeting to individuals in the assistance unit is counted in determining eligibility.

IV. Although a separate eligibility determination is not needed, TANF recipients get medical coverage because they qualify as a Section 1931 coverable group.

If a family member not included in the TANF grant wants coverage that member's legal parent(s) must be included in the assistance unit with the family member. The parent's share of the TANF grant is countable income.

For example, Ms. Soma gets a TANF benefit for herself and her 16 year old son. Her 19 year old also wants coverage. Ms. Soma, her income and her share of the TANF grant must be included in the assistance unit with the 19 year old. Alternatively, all 3 family members and their income including the TANF grant may be considered as 1 assistance unit.

If a family is getting the maximum grant, the share of the TANF grant attributed to the adult is the maximum grant amount for 1 adult. The share of the TANF grant attributed to the other members of the TANF filing unit including a 2nd adult is determined by dividing the remaining grant amount by number of other individuals in the TANF filing unit.

If the family has a TANF grant that is less than the maximum, the share attributed to each member of the TANF filing unit is the grant amount divided among the members of the filing unit.

1130 REFERRALS

1131 REFERRALS TO CHILD AND ADULT PROTECTIVE UNITS

In compliance with federal and State statutes, when information is brought to the attention of a staff member or there is reasonable cause to suspect child abuse, neglect or exploitation, an immediate referral will be made to the Child or Adult Protective Unit which will investigate the suspected abuse.

1132 REFERRAL TO THE FRAUD INVESTIGATION UNIT

If it appears that a recipient has purposely misrepresented actual circumstances (such as living arrangement, income, or assets) in order to receive Medical Assistance, and the individual would not have been eligible to the same extent had the proper information been available at the time of application, redetermination of eligibility, or within 10 days of the change in circumstances, a referral to the Fraud Investigation Unit will be made. (See Section 1420.).

The report will include:

I. a detailed explanation of the misrepresentation and the effect it had on eligibility.

II. a claims history indicating the services that should not have been paid.

Complaints received directly by the Fraud Investigation Unit from the community will be screened through the Director of the Medical Assistance Program to see if the individual is an active or former recipient. The Director will check the status and direct the Fraud Investigation Unit to the proper regional office if eligibility has existed. The Fraud Investigation Unit will then share its information with the regional office which in turn will determine the effect this information has on eligibility.

1133 OUTREACH

Public Law 1978, Chapter 714, requires the Department of Human Services to inform low-income households of the availability and benefits of the medical assistance programs the Department administers and provide reasonable and convenient access to the programs. The Department publishes a pamphlet explaining covered services and eligibility.

1140 CONFIDENTIALITY

The Department of Human Services, in accordance with Federal (42 CFR 431.306) and State statutes, must maintain individual's information in a manner which will ensure that this information is restricted to persons or agency representatives who are subject to standards of confidentiality comparable to those of the Department of Human Services.

Information from the case record will be released under the following circumstances:

I. The individual has the right to review information in the case record at any time. When the medical source requests that the medical information be kept confidential, that information may not be reviewed by the individual.

II. All information pertaining to a decision of eligibility for assistance, including medical and social data for preparation of a fair hearing (See Section 1180) will be made available to the individual or the individual's representative. If the individual is being represented by an attorney, permission to release information to the attorney must be obtained in writing from the individual.

III. Financial information relating to eligibility will be given to general assistance administrators if necessary for making a determination of granting general assistance. Release of medical reports to authorities will be made only if the individual has signed a written release.

IV. Information relating to whether an individual is a recipient in a particular month will be given to hospitals, physicians, pharmacists, and other medical suppliers inquiring in order to determine whether to provide their service under the Medical Assistance Program. The address of the individual is not to be released.

V. Information necessary for agencies within the Department or those contracting with the Department to administer their programs may be given. These agencies include the adult and child protective units, Support Enforcement and Location Unit (SELU), Fraud Investigation Unit, Preventive Health Program (PHP), Social Security, Special Services Unit, and Community Action Program.

VI. Information will be made available to other social service agencies upon receipt of written authorization from the individual (or adult family head in the case of children) giving the Department authorization to release information to the following:

A. federal and State legislators;

B. attorneys;

C. social or financial service agencies requesting information beyond eligibility dates, or, if under contract with the Department, information beyond that necessary to administer their program.

VII. In the event of the issuance of a subpoena or order from the court for the case record or for any agency representative to testify concerning an applicant or recipient, the Department's attorneys will call the Court's attention to the statutory provisions and the regulations against disclosure of information. The decision in regard to release of information will be with the presiding judge.

VIII. Information about whether the individual is receiving Medical Assistance, the number of children in the assistance unit and the address of the children will be made available to absent parents inquiring about the status of the family only with written permission of the caretaker relative.

With all other requests, a written release from the individual is required prior to sharing the information.

When Medical Assistance Eligibility Specialists need collateral information, the individual must be informed of the Agency's need and a completed release form obtained. (See Section 1410.)

Information in case records and computer files will be used only for Agency business, never for obtaining information about friends, relatives or neighbors. Employees of the Department are not permitted to determine their own eligibility or that of their immediate family.

The name of individuals supplying information who wish to remain anonymous will not be kept in the case record.

1150 RECORD RETENTION

Material is kept for auditing purposes for three years. Material over three years old may be destroyed except for the first application which should be kept even if it is over three years old.

Individual case records are not to be filed in Archives for historical preservation and future review by historians or anyone else. Such retention has no bearing on the administration of the Medical Assistance Program.

The only exception to this procedure is a case which has been referred to the Fraud Investigation Unit or Attorney General for collection or prosecution purposes. These case records shall be clearly marked "Do Not Destroy".

1160 OUT-OF-STATE COVERAGE

Medical Services provided outside of the State of Maine are coverable under the following circumstances:

I. Individuals are eligible for payment of services to qualified providers as long as the provider is located within 15 miles of the Maine-New Hampshire border or within 5 miles of the Maine-Canada border.

II. Individuals temporarily absent from the State are eligible for emergency services only unless travel to return to the State of Maine would endanger the individual's health.

III. Individuals with Medicare may receive services from providers who accept Medicare assignment in any state.

IV. Individuals who intend to remain out-of-state and are making application for assistance in that state remain eligible until the other state determines eligibility or ineligibility.

V. Any other out-of-state medical care requires prior authorization from the Bureau of Medical Services. Prior authorization for medical treatment out-of-state may be available if such treatment is only available outside the State of Maine or if such treatment can be obtained outside Maine at less total expenses than inside Maine (see Medical Assistance Manual).

1170 REPLACEMENT OF MEDICAL IDENTIFICATION CARDS

In those instances when an individual reports the loss or non-receipt of a medical identification card, the Medical Assistance unit will issue a replacement card.

Before replacement can take place, the individual must furnish the Department with identifying information such as name, medical identification number, Social Security number, or date of birth.

Requests may be made by telephone, in writing, or in person.

The Medical Assistance unit will issue replacement cards for those individuals for whom they maintain case records or for SSI recipients. TANF or Child Welfare recipients may be referred to the appropriate TANF or Social Services unit.

When data in the computer indicates that the individual's medical card is restricted, the replacement card must be obtained from the Recipient Relations Unit in Augusta unless the case records show what the restriction is.

1180 FAIR HEARINGS

NOTE: For additional information on the preparation of a Fair Hearing, see Appendix A.

A Fair Hearing is an informal conference held by the Commissioner of the Department or someone designated by the Commissioner to review the action taken by the Department in order to ensure that State policy has been applied correctly.

Federal and State laws assure that any individual or the individual's representative who believes that proper consideration has not been given to circumstances surrounding a request for assistance may request a fair hearing.

This right is basic throughout all of the public assistance programs. All complaints which are not clear requests for a fair hearing will be answered by a personal contact or in writing by the Medical Assistance Eligibility Specialist, supervisor, or member of Central Office staff and will explain the individual's right to a fair hearing. If the individual is satisfied with the adjustment or explanation, activity on the complaint will end. The review of the decision shall include consideration of:

I. the Agency's failure to act with reasonable promptness. This includes undue delay in reaching a decision about eligibility or refusal to consider a request for assistance and termination or reduction of assistance;

II. an Agency decision regarding.

A. eligibility for assistance in both initial and subsequent determinations;

B. the level of coverage granted.

A review of the decision need not be granted when either State or federal laws require automatic adjustments for classes of recipients unless the reason for an individual's appeal is disagreement of facts affecting eligibility (such as incorrect computation).

Written notification of the right to a fair hearing is given to all interested parties through the use of pamphlets and informational materials. This information is also printed on all routine notices.

It must be assured that the individual understands the process. When a request is made, the Agency will not limit or interfere with the individual's rights in any way. In fact, the emphasis of the Agency will be on helping the individual submit the request and prepare the case. The Department's regional office will provide information regarding legal services available in the community to assist the individual in representation at fair hearings. The Medical Assistance Eligibility Specialist and other Agency representatives involved in the decision will participate in the fair hearing conference. All participants will testify under oath.

Every written notification of Agency action on eligibility will include:

I. the right to a fair hearing;

II. the method by which a hearing can be obtained;

III. the right to be represented by legal counsel, relative, friends, or other persons. The Department cannot pay for legal services.

Either party may subpoena witnesses and evidence by request through the Hearing Officer who will refer the issue to the Assistant Attorney General. However, the party requesting the subpoena will bear any expenses of issuance and costs of reimbursement to witnesses.

If, at any time during the Adverse Action Notice Period the individual requests a Fair Hearing, assistance will be continued until the Fair Hearing decision is rendered or the Fair Hearing Officer determines during the Hearing that the sole issue is one of State or federal law. When the sole issue is one of State or federal law requiring automatic adjustment for some recipients, the notice will be given and the action made effective immediately.

NOTE: Closure of temporary coverage is a denial and restoration of benefits cannot be made.

If a Fair Hearing is requested after the 12 day period, (10 days for notice plus 2 days for mail) assistance will not be continued or reinstated at its previous level pending a decision.

Any clear expression that the individual or individual's representative wants an opportunity to present the case to a higher authority is a request for a Fair Hearing. A Fair Hearing may be requested orally or in writing by the individual or the individual's representative to the Commissioner of the Department of Human Services or a designee. If the Commissioner authorizes another agent to handle the Fair Hearing, such a person must be:

I. impartial and not have participated in the action causing dissatisfaction;

II. sufficiently skilled in interviewing to obtain evidence and the facts necessary for a fair determination;

III. qualified to evaluate all evidence fairly and realistically, to explain to the individual the policies under which the Agency operated, and to interpret and inform the Agency of any evidence of unsound, unclear or inequitable policies or practices.

The Department may deny or dismiss a request for a Fair Hearing when:

I. the request is withdrawn in writing by the individual or individual's representative;

II. the sole issue is one of State or federal law requiring automatic adjustment for groups of recipients; or

III. the Fair Hearing is abandoned. Abandonment occurs when the individual or the individual's representative fails to appear at the Hearing without a reason acceptable to the Hearing Officer.

The Department may respond to a series to individual requests for fair hearings by conducting a single group hearing. The Department will consolidate only cases in which the sole issue involved is one of a single policy issue. If individuals request a group hearing on such an issue, the Department will grant it. In all group hearings, the policies governing fair hearings will be followed. Thus, individuals will be permitted to present their own cases and to be represented. If, at any time, an individual scheduled for a group hearing wants to withdraw and have an individual hearing, it will be arranged.

Any request for a fair hearing must be received within 30 days of the date of action unless the Department decides to grant an extension of time.

A request for a hearing will be acknowledged in writing within 5 days of its receipt. If the eligibility specialist has not prepared a fair hearing report, a request for a fair hearing will be forwarded to the Fair Hearing Unit with a note that a report will follow. On receipt of the request, the Fair Hearing Unit will send a written acknowledgment to the individual. A written report of the actions taken which resulted in the request for the fair hearing will be forwarded to the Fair Hearing Unit by the Eligibility Specialist within 10 days of the request for the hearing. The Fair Hearing Unit will then send a hearing notice to the individual and the individual's representative. The hearing notice will contain the date, time and place of the hearing. The hearing will be scheduled after considering the convenience of the individual. The notice will be sent at least 10 days prior to the hearing to allow for preparation of the case.

A copy of the hearing request and acknowledgment letter will be forwarded to the regional office. The Medical Assistance Eligibility Specialist will review the circumstances prior to the hearing and will submit a report to the Fair Hearing Officer. The person who had primary responsibility for the decision will furnish the required reports. If the review results in a satisfactory adjustment or explanation, the individual may make written withdrawal of the request for a fair hearing which will be forwarded immediately to the Fair Hearing Officer.

When additional medical information is requested by the individual, it will be obtained at agency expense from a medical source satisfactory to the individual. The Fair Hearing Officer can also consider the physician's report or can request additional evidence. The medical report will be made in writing or by personal testimony for the hearing record. When the hearing involves medical issues, a medical assessment other than that of the persons involved in making the original decision will be obtained and made a part of the record if the hearing officer or the individual considers it necessary.

The individual or the individual's representative will have the opportunity to:

I. examine all documents and records pertinent to the hearing;

II. present the case with or without the aid of others;

III. bring witnesses;

IV. establish all pertinent facts and circumstances;

V. present any arguments without interference;

VI question or refute any testimony or evidence;

VII. confront and cross examine adverse witnesses.

Information not contained in the case record cannot be used at the hearing. The Fair Hearing Officer will not review the case record or other material prior to the hearing unless such material is made available to the individual or the individual's representative.

All fair hearings will:

I. be conducted privately and be open only to the individual, anyone present at the individual's request, and members of the Department's staff, or others selected by the Fair Hearing Officer for their participation in the hearing;

II. be conducted informally without technical rules of evidence. hearings will be subject to the requirement of due process. All witnesses will testify under oath;

III. be opened by the Fair Hearing Officer who will make a statement of points in issue, give all participants an opportunity to present oral or written testimony or documentary evidence, offer rebuttal, question witnesses, examine all evidence presented at the hearing, and establish competency of witnesses offering subjective or technical opinions;

IV. be recorded to be available to members of the Department and to the individual or individual's representative. All documentary evidence submitted as exhibits at the hearing will be available;

V. be concluded when the Fair Hearing Officer and the individual or individual's representative are satisfied that all available evidence has been introduced and properly examined;

VI. result in a decision based exclusively on evidence or testimony presented at the hearing.

The fair hearing process will take no longer than 60 days from the date of the initial request for the hearing except when the individual requests a delay. If the request for a delay is granted, additional time may be added to the 60 days. When a fair hearing is requested regarding the determination of the community spouse asset allowance (Nursing Care - Section 4021.1), the hearing will be held within thirty (30) days of such request. Following the hearing, a report will be prepared by the Fair Hearing Officer. The report will contain:

I. a statement of the issue;

II. a list of participants;

III. relevant facts brought out at the hearing and items introduced into evidence;

IV. pertinent provisions in Department's policy governing the decision;

V. the decision and the basis for the decision.

A copy of the hearing report will be sent to the individual, the individual's representative, and the regional office.

Hearing decisions shall be binding on the Department.

1181 RIGHT TO JUDICIAL REVIEW

Within five days of the decision by the Fair Hearing Officer, the copy of the decision and notice of the individual's rights to judicial review under Maine Administrative Procedure Act 5 M.R.S.A., Sec. 11001 et seq. will be mailed to the individual and the individual's representative. The Notice will also advise the individual that to take advantage of this right, a petition for review with the Superior Court must be filed within 30 days of the receipt of the decision.

1200 BASIC ELIGIBILITY REQUIREMENTS

1210 CITIZENSHIP

The Immigration Reform and Control Act of 1986 requires all members of a household applying for full Medical Assistance to declare, in writing on Form IM-076, their citizenship or alien status. An adult household member can make this declaration for the entire household with their signature. This declaration of alien status is not a requirement for retroactive Medicaid coverage for emergency medical services. (See 1210.1)

An individual must be a citizen of the United States or a lawfully admitted alien. An individual who is not a citizen of the United States must be an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under the color of law (including any alien who is lawfully present in the United States as result of the application of the provisions of Section 203(a)(7), 207(c), 208 and 212(d)(s) of the Immigration and Nationality Act). An individual who has resided in the United States continuously from any date before January 1, 1972, is considered a legally admitted alien.

Failure to comply with this requirement causes ineligibility for each individual for whom declaration of citizenship or alien status has not been made. Sanctions will be applied and income and resources treated as are those of an individual failing to comply with Social Security number requirements (Section 1250). Information around refusal to sign this form or admission of illegal alien status will not be shared with Immigration and Naturalization Services. All information will be held confidential in accordance with Section 1140.

Each person who is not a U.S. citizen, will need to provide either documents from the Immigration and Naturalization Service or other documents which prove the immigration status. Alien status is subject to verification by the Immigration and Naturalization Services.

There is a special program for refugees. See Section 2150.01.

1210.1 RETROACTIVE COVERAGE ONLY

An individual, who is either an illegal or ineligible alien as defined below, can receive retroactive Medicaid coverage for emergency medical services only. They must still meet income and asset tests, and must be in a coverable group. These individuals are <u>not</u> required to declare their citizenship or alien status or supply a Social Security number when applying for retroactive medical coverage only.

I. *Illegal alien* - aliens not eligible for amnesty who have entered the country unlawfully.

II. *Ineligible alien* - aliens legally admitted on a temporary basis. The following are examples of individuals who are ineligible aliens:

   A. Foreign government representatives on official business and their families and employees;

1210.1 cont.

B. Visitors for business or pleasure, including exchange visitors;

C. Aliens in travel status while traveling directly through the United States;

D. Crewmen on shore leave;

E. Treaty traders and investors and their families;

F. Foreign students;

G. International organization personnel and their families and servants;

H. Temporary workers, including agricultural contract workers;

I. Members of foreign press, radio, film or other information media and their families.

These aliens should have one of the following types of documents: I-94, Arrival-Departure Record; I-185, Canadian Border Crossing Card; I-186, Mexican Border Crossing Card; SW-434, Mexican Border Visitor's Permit; I-95A, Crewman's Landing Permit; or I-184, Crewman's Landing Permit and Identification Card.

1210.2 Reserved

1210.3 DOCUMENTATION AND VERIFICATION

An individual who is not a citizen or national of the United States must present alien registration documentation, other proof of immigration registration from the Immigration and Naturalization Service, or other documents indicating the individual's satisfactory immigration status. If documentation is not presented at application, the individual will be given an opportunity to provide the documentation within a time frame used for all Medicaid applicants that allows the Department to meet its 45 day processing standard (Section 1431).

The Systematic Alien Verification for Entitlements Program is the Immigration and Naturalization Service operative system for verification of immigration status of aliens applying for Medicaid. Primary verification will be obtained through touch-tone access to the INS-ASVI system. If no record is found, secondary verification procedures will be necessary. No eligible documented alien will be denied benefits based solely on information from the ASVI system. Ineligibility can be determined only following the secondary verification procedures in which a written request for verification is mailed to the U.S. Immigration and Naturalization Service.

1220 RESIDENCE

Each individual for whom assistance is being requested must be a resident of Maine.

Each individual must be living in the State voluntarily with the intention of making a home in Maine.

An individual who is visiting or in Maine temporarily is not a resident. The individual should apply to the actual state of residence for medical assistance. However, if the individual is living in Maine and has entered the State with a job commitment or seeking a job (even if only a temporary job, e.g., migrant workers), the individual is a resident of Maine.

A child whose caretaker relative may be considered a resident of Maine is also considered a resident.

In any situation where a child is eligible for a Title IV-E payment (including the Federal Adoption Assistance Program) from another state, the state of residency, for Medicaid purposes, is the state in which the child is physically living. (See Section 2150.3.) Children who are receiving services under the Interstate Compact for Children who are not receiving Title IV-E payments from another state are not considered residents of the State of Maine.

1220 cont.

Eligibility cannot be denied or terminated because:

I. an individual has not resided in the State for a specified period;

II. the individual did not establish residence before entering a medical institution;

lll. an individual is temporarily or involuntarily absent from the State, provided the individual intends to return once the purpose of the absence has been accomplished, unless another state has determined the individual is a resident there.

1221 INDIVIDUAL IN A MEDICAL INSTITUTION

I. If a state arranges for an individual to be placed in an institution located in another state, the state making the placement is the individual's state of residence, regardless of the individual's indicated intent or ability to indicate intent.

II. For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is that of the individual's parents, or legal guardian. If the parents reside in separate states and there is no appointed legal guardian, the state of residence is that of the parent applying for Medical Assistance on the individual's behalf.

III. For an institutionalized individual who became incapable of indicating intent on or after age 21, the state of residence is the state in which the individual was living when the individual became incapable of indicating intent.

IV. The state where the institution is located is the individual's state of residence unless that state determines that the individual is a resident of another state by applying the rules under (2) or (3) above.

V. For any other institutionalized individual, age 21 or over, the state of residence is the state where the individual is living with the intention to remain for an indefinite period of time.

VI. An individual is considered incapable of indicating intent if:

A. the individual has an I.Q. of 49 or less or has a mental age of 7 or less based on tests acceptable to the Bureau of Mental Retardation;

B. the individual has been judged legally incompetent; or

C. medical or other acceptable documentation supports a finding that the individual is incapable of indicating intent.

1230 SOCIAL SECURITY NUMBERS

I. Who must comply:

A. All individuals are requested to obtain a Social Security Number.

The individuals who are required to comply with these requirements are:

(1) parents or other specified relatives applying on behalf of themselves and their children,

1230 cont.

(2) individuals age 18 and over who are applying on their own behalf,

(3) individuals under age 18 who are applying on their own behalf and who are married or in the military.

This provision does not apply to undocumented non-citizens and , except for (3) above, to individuals under age 18.

An individual who does not comply with this requirement is not eligible for Medicaid. In (1) above it is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

II. What is required:

A. furnish the Department with a Social Security number. If the individual has a Social Security number but is unable to provide it, the Department must contact the Social Security Administration in order to obtain the number;

B. apply to the Social Security Administration for a Social Security number if the individual does not have a Social Security number. The applicant or recipient must provide the Department with verification that the application for a Social Security number has been made. The Social Security number will be provided by the Social Security Administration.

C. If a newborn is eligible under the provisions of 2423, there is no Social Security number requirement up to the age one (1). Otherwise, the requirements for a newborn child must be met by the first day of the second month following the month in which the child's mother is discharged from the hospital.

EXAMPLES:

(1) A child is born on July 3rd. Mother leaves the hospital on July 6th. Application for a Social Security number for the child must be completed by September 1st.

(2) A child born on July 31st. Mother leaves the hospital on August 2nd. Application for a Social Security number for the child must be completed by October 1st.

The Medical Assistance Eligibility Specialist should explain that the application for a Social Security number requires the individual to provide a valid birth certificate or other proof of age and verification of identity to Social Security.

The Department must assist the individual in obtaining verification necessary to apply for a Social Security number. This includes obtaining documents to prove date of birth, citizenship or identity if these materials cannot be provided by the individual. The Department cannot pay any costs incurred in obtaining this information.

1230 cont.

III. Non-Compliance

A. If an individual who is required to do so fails to apply for or furnish a Social Security number Medical Assistance must be denied or terminated. (See Section 1250, "Sanctions".)

B. Medical Assistance will not be withheld or terminated for lack of a Social Security number as long as an individual provides verification of application for a Social Security number for those requesting assistance. Medical Assistance will not be withheld or terminated while verification of the individual's Social Security number is being obtained from the Social Secuirty Administration.

1231 RETROACTIVE COVERAGE

Retroactive coverage may be granted if the Social Security number requirements are met during the application process. If the Social Security number requirements are not met, but at a later date the individual cooperates with these requirements, the retroactive coverage cannot be granted.

1231 cont.

EXAMPLES:

l. A parent refuses to apply for a Social Security number. The parent is denied coverage. One month later, the individual agrees to comply. The parent is eligible, effective the first day of the month in which the application for a number is made. Retroactive coverage cannot be granted.

II. A parent refuses to apply for a Social Security number. Coverage for the parent only must be denied. A year later, the person reapplies and gives a Social Security number proving application for the number was made six months previously. Eligibility may be authorized with up to three months' retroactive coverage because the applicant complied with the Social Security number requirements prior to the retroactive period.

Individuals must be informed that the Social Security number will be utilized in the administration of the Medical Assistance Program and will be used for verification of information such as wages, unemployment benefits and bank accounts.

1240 ASSIGNMENT OF RIGHTS TO MEDICAL PAYMENTS (REFERRAL TO TPL)

I. Who must comply:

A. As a condition of eligibility, certain individuals must assign to the Department of Human Services their rights to payment for medical care from any third party and cooperate in obtaining these medical payments. This is done by a referral to Third Party Liability (TPL).

These individuals are:

(1) parents or other specified relatives applying on behalf of themselves and their children,

(2) individuals age 18 or over who are applying on their own behalf,

(3) individuals under age 18 who are applying on their own behalf who are married or in the military.

This provision does not apply to pregnant women.

An individual who does not comply with this requirement is not eligible for Medicaid. In (1) above it is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

1241 cont.

II. What is required:

The individual must:

A. Assign rights to payment for medical care;

B. cooperate with the Third Party Liability Unit in obtaining medical payments; or

C. relinquish medical payments received directly from a third party resource which were intended to cover services paid by Medicaid.

D. An individual may not be denied or terminated if the individual refuses to assign to the Department of Human Services any rights to Veteran's Aid and Attendance Benefits. Aid and Attendance Benefits are provided by the Veteran's Administration to assist individuals in payment of increased medical services.

E. Items, for both prospective and retroactive periods, which must be reported include:

(1) any court ordered responsibility to pay medical bills by a parent, unless it can be demonstrated that contact with the parent by the Third Party Liability Unit (TPL) or Support, Enforcement and Location Unit (SELU) could cause harm;

(2) medical insurance (except Medicare) covering the applicant or recipient. This includes private insurance, group insurance, Champus, and supplemental policies such as companion plans from Blue Cross/Blue Shield, Major Medical and indemnity insurance. Reporting is required whether the cost of premiums is paid by the individual, employer, or another person;

1240 cont.

(3) the portion of Worker's Compensation benefits for medical services for which the recipient is applying, receiving, or which terminated during the retroactive eligibility period;

(4) information regarding settled or pending lawsuits involving personal injury.

III. Non-compliance:

A. If an individual who is required to do so fails to comply with these provisions, Medical Assistance is denied or terminated (see Section 1250, "Sanctions").

1240.1 ASSIGNMENT OF SUPPORT RIGHTS - COMMUNITY SPOUSE

A referral will be made to the Third Party Liability Unit on behalf of the institutionalized spouse who gains eligibility for nursing care assistance when deemed assets are not made available by the community spouse.

1241 COOPERATION IN OBTAINING MEDICAL SUPPORT FROM THE NON-CUSTODIAL LEGAL PARENT AND ESTABLISHING PATERNITY

I. Who must comply:

A. Certain individuals must cooperate in obtaining medical benefits from the non-custodial parent of a dependent child and in establishing paternity (see Section 2010). If the individual can show that good cause for not cooperating exists, no referral will be made.

These individuals are:

(1) parents or other specified relatives applying on behalf of themselves and their children unless the assistance group is being covered under Transitional Medicaid,

This provision does not apply to pregnant women or individuals covered under Transitional Medicaid.

An individual who does not comply with this requirment is not eligible for Medicaid. In (1) above it is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

1241 cont.

II. What is required:

The individual must:

A. identify and help locate those parents of a dependent child for whom Medical Assistance is requested;

B. aid in establishing paternity of a child born out of wedlock.

Cooperation includes responding tor requests for information from DSER and appearing as a witness at a judicial or other hearing or proceeding.

III. Non-compliance

A. If an individual who is required to do so fails to comply with these provisions, Medical Assistance is denied or terminated (See Section 1250, “Sanctions”).

1242 GOOD CAUSE

Every Medical Assistance applicant or recipient will have the opportunity to claim good cause for refusing to cooperate.

When the individual claims good cause, sanctions will not be implemented unless it is finally determined that good cause does not exist.

Cooperation requirements, sanctions, and the right to claim good cause must be explained to the individual. The Medical Assistance Eligibility Specialist must inform the individual that SELU may attempt to establish paternity and collect medical support in cases where there is no risk to the individual or children.

If the individual thinks that attempts to establish paternity or collect support would pose a risk to the individual or children, the individual must provide evidence to substantiate the claim of good cause not to cooperate.

The Medical Assistance Eligibility Specialist must document the reasons for granting or denying the claim of good cause and must notify the individual of the decision in writing. If the decision is not to grant good cause, the individual must be given the opportunity to withdraw from the Program or provide additional information to substantiate the claim. The Medical Assistance Unit makes the final determination of good cause.

The individual's eligibility will be determined prior to granting or denying good cause. Referral of the parent who is not in the home to TPL will not be made while the decision is pending. If good cause is granted, no referral will be made.

If good cause is not granted and the individual continues to refuse to cooperate, sanctions will be applied and the TPL unit and SELU will proceed without the individual's cooperation.

The Medical Assistance Eligibility Specialist must discuss the above with the individual at the time of the application.

Good cause for not cooperating may be claimed by the individual if the individual can demonstrate that:

I. cooperation may reasonably be anticipated to result in

   A. physical or emotional harm to the child; or

   B. physical or emotional harm to the caretaker relative which would hinder the ability to care for the child.

II. legal proceedings for adoption of the child are pending before a court or the individual has been working with a social agency to decide whether to relinquish the child for adoption.

1242 cont.

III. the child was conceived as the result of rape or incest.

Documents from court records, law enforcement agencies, medical sources, social service agencies and any other legal document may be used to substantiate rape, adoption and physical or emotional harm to the child or caretaker relative. If such documents are unavailable, information may be secured from other sources familiar with the claims of the individual. The Agency should assist the individual in obtaining the required evidence, but no contact with collateral sources will be made without the individual's knowledge and consent.

A contact with the absent parent or putative father should be made only if it is essential to the claim for good cause. Contact should not be made until the applicant or recipient has the opportunity to:

I. present additional evidence or information which makes contact with the absent parent or putative father unnecessary;

II. withdraw the application for assistance, or have the case closed;

III. have the good cause claim denied.

1250 SANCTIONS

I. When an individual is not eligible for Medicaid because they do not comply with the provisions to apply for a Social Security Number, cooperate with DSER or cooperate in a referral to TPL, the individual is included in the assistance group size and the individual's income and assets are used to determine eligibility for the assistance group.

II. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level.

III. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the assistance unit.

1260 INDIVIDUALS RESIDING IN PUBLIC INSTITUTIONS

I. Inmates of the state prison, Maine Youth Center, local or county jails:

If the individual meets financial and non-financial criteria applicable to non-inmates, Medicaid coverage is authorized. Medicaid will only pay for any Medicaid coverable in-patient service provided to the inmate while they are an in-patient in a hospital, nursing home, intermediate care facility for the mentally retarded (ICF/MR) or juvenile psychiatric facility.

II. Individuals admitted to reside in a public (or private) medical institution classified as an IMD (Institution for Mental Disease) for over 30 days: Spring Harbor, Acadia, AMHI, BMHI:

A. if age 21 or over and under age 65, these individuals are not Medicaid eligible until they are conditionally or unconditionally released or are on convalescent leave from the facility.

B. if under age 21 (through age 20) and age 65 or over, Medicaid coverage is available for all Medicaid coverable services.

1270 OTHER BENEFITS

Individuals must take all appropriate steps to obtain benefits to which they are entitled. This includes applying for the benefit and providing the other benefit source with necessary information to determine eligibility for the benefit. Other benefits for which the individual must file include Social Security, Railroad Retirement, Veteran's Pension/ Compensation, Worker's Compensation, Unemployment Insurance. This provision does not apply to SSI, State Supplement TANF cash benefits and other Federal, State, local or private programs which make payments based on need.

Do not require an individual to file for other benefits when applying for them would result in no additional benefit which affects the individual's eligibility.

Do not require the individual to pursue a claim for other program benefits through the appeals process.

Do not require an individual who is not applying for or covered by Medicaid to pursue a claim for other program benefits, for example, an ineligible spouse, parent or child.

1300 APPLICATION PROCESS

An application is the initial request for Medical Assistance coverage made by signing the Agency's application form. The individual or anyone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed application form is received in any regional office or for pregnant women, the date the form is signed and dated by both the applicant and the designated person at specified provider sites.

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

An application which is denied is valid for the month of application and the following month.

EXAMPLE:

An individual applies in January seeking retroactive and prospective coverage. The person's assets are below the asset limit for the retroactive period. They exceed the asset limit for January. The application is denied for prospective coverage, however retroactive coverage is given. In February, the individual verifies that assets are below the asset limit and provides a written request for prospective coverage. Prospective coverage may be granted beginning February 1st based on the written request for coverage. It is not necessary for the individual to complete another application form. The 45-day processing standard (See Section 1431) begins with the date that the written request is received.

A reapplication is any signed application form received after the Adverse Action Notice Period. This includes review forms returned after that period.

All applicants or reapplicants for Medical Assistance will be given information in writing, or verbally if appropriate, about the following:

I. services covered under Medical Assistance;

II. conditions of eligibility;

III. the individual's rights, including Fair Hearings;

IV. responsibilities of recipients, including reporting changes within ten days (See Section 1420);

V. the 45-day application processing standard (See Section 1431.)

1400 CLIENT AND AGENCY RESPONSIBILITIES

1410 VERIFICATION OF ELIGIBILITY FACTORS

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary and the individual does not give consent, denial or termination must occur.

When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be denied or terminated. Denial and termination will be carried out in conformance with the rights of individuals, including an advance notice of adverse action and the right to request a fair hearing.

It is the responsibility of the Agency to assist the individual in establishing eligibility for medical assistance**. It is the responsibility of the individual to satisfy all eligibility requirements**. The individual or the individual's representative is responsible for supplying verification of information to all persons in the household whose circumstances affect eligibility. If this information is not provided, eligibility does not exist.

1420 REPORTING RESPONSIBILITIES

It is the responsibility of the individual to report changes of income, assets, household composition and any other change in circumstances which affect eligibility for Medical Assistance. Such change is to be reported within 10 days from occurrence. For income purposes, "occurrence" will be considered the date the increased income was received. For all other purposes, "occurrence" will be considered the date the change took place.

Eligibility will be recalculated within thirty days of the receipt of new information which may affect the level of Medical Assistance coverage or cause ineligibility.

1430 PROCESSING STANDARDS

1431 45-DAY PROCESSING STANDARD

The 45-day processing standard is the result of a consent decree (Polk et al. vs. Longley). The consent decree stated that all applications must be acted upon and a decision made as quickly as possible. The applicant must be sent a notice of the decision no later that 45 days after the date of application. If a decision of eligibility is not made within 45 days and there is no documentation that the applicant or the applicant's source of medical information has not cooperated in obtaining information necessary to make a decision, temporary medical assistance must begin on the 46th day. If an individual is waiting for a decision of medical eligibility or there is another Agency delay, and a deductible has been determined, temporary coverage begins on the 46th day or the day following the date the deductible is met, whichever is later.

Documented noncooperation by the applicant or the source of the applicant's medical information means that the case record must contain sufficient information to show that the applicant or the source of the applicant's medical information was requested to provide specific information or verification, or carry out particular activities necessary to establish eligibility and that the applicant or medical source failed or delayed in doing so within a reasonable period of time. When documented noncooperation exists, the applicant is not to be issued the medical eligibility card for temporary coverage.

When the application involves a determination of incapacity or disability and it is necessary to obtain medical reports from physicians, hospitals, or other medical sources, such medical information must be requested from all necessary sources within 5 days after the date of application. If the reports are not received within 15 days of the first request, a second request must be sent. The applicant is to be notified whenever a second request is made to inform the individual that the necessary medical reports have not been received.

1432 10-DAY PROCESSING STANDARD

The consent decree filed as a result of Polk et al. vs. Longley also mandates that the Department issue a medical card no later than 10 days after the applicant furnishes adequate information about incurred medical expenses in order to meet the deductible. Adequate information includes the date, cost, type of service and amounts payable by insurance and other third parties for submitted bills.

If the person is not issued a medical card within 10 days of submitting the information, the Medical Assistance Eligibility Specialist must issue a temporary card, effective on the 11th day unless there is documentation that the individual is not cooperating.

1433 ADJUSTMENT OF TEMPORARY COVERAGE

If the applicant is determined to be eligible after the temporary Medical Assistance card has been issued, the coverage dates will be adjusted to reflect the applicant's eligibility period.

If the applicant is found to be ineligible after the temporary card has been issued, the applicant is to be sent a notice of denial. There is no Adverse Action Notice Period. The applicant becomes ineligible upon the receipt of the denial notice (three days from the day the notice is mailed). In no instance may the eligibility dates be adjusted to eliminate coverage for the period between the 46th or 11th day and the date of notification. The individual may request a fair hearing regarding the denial, but coverage will not continue pending the fair hearing decision. If the decision of the Fair Hearing Officer is to remand the case back to the regional office for a new decision, temporary coverage is reinstated back to the date that the coverage stopped.

No payment for medical services provided to the individual during the period when the applicant was eligible for temporary coverage is recoverable from the applicant.

1440 NOTICES

1441 NOTICE OF ELIGIBILITY OR INELIGIBILITY

Individuals will be notified in writing as soon as eligibility is determined. If some of the individuals applying for medical assistance are eligible and some are not, the notice must specify who is or is not eligible and the reasons for each individual's ineligibility.

Individuals whose eligibility begins after the month of application must be sent a denial notice for the months of ineligibility.

All individuals who apply for medical assistance must be notified of their eligibility for retroactive coverage. Such notification must indicate the months of eligibility or ineligibility.

When an individual is determined to be ineligible, the notification will contain:

I. a statement that the application has been denied;

II. the specific reason(s) for the denial;

III. the manual citations which support the decisions;

IV. an explanation of the individual's right to request a fair hearing;

V. a recommendation of any other Medical Assistance programs administered by the Department for which the individual might be eligible.

1442 ADVERSE ACTION PERIOD

In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient.

"Timely" means that the notice must be mailed 12 days before the intended change would be effective (10 days for notice plus 2 days for mail).

EXCEPTION:

Timely actions resulting from computer matching mass changes to Social Security and other Federal benefits require an advance notice of 30 days prior to the effective date of the action.

"Adequate" means a written notice which includes a statement of

I. the action the Department intends to take;

II. the reasons for the intended action;

III. the regulations supporting such action;

IV. an explanation of the rights to request an Advance Conference and a Fair Hearing;

V. a statement explaining that if a Fair Hearing is requested within the notice period, the intended action will not become effective until after a Hearing Decision is rendered.

The only situations in which the timely notice guarantee is not required are as follows:

I. factual information is received confirming the death of the recipient;

II. a written statement that assistance is no longer wanted is received by the Department. Such statement must be signed by the recipient or the recipient's representative;

III. the recipient has been committed to a public institution (See Section 1260);

IV. the recipient is determined to need skilled nursing care, intermediate care, long-term hospitalization, or any other nursing care status;

V. the recipient's cost of care changes (See Section 4530);

VI. the recipient's whereabouts are unknown and departmental mail directed to the recipient has been returned;

VII. An applicant for Medical Assistance has been covered temporarily due to the Department's failure to determine eligibility within the 45-day time limit and is later found to be ineligible. The applicant's temporary coverage is to end 3 days from the date the denial notice is sent;

VIII. Documentation is obtained that the individual is currently receiving Medical Assistance in another state.

Unless the termination of assistance is based on the death of the only member of the assistance unit, written notice of the adverse action is required.

1500 ELIGIBILITY PERIODS/REVIEWS

An individual's dates of eligibility are based on the month the application is received. Eligibility for retroactive coverage may be determined for up to three months prior to the month of application. (See Section 1530.) Eligibility for the prospective period is determined for six months for Medically Needy or one year for Categorically Needy including the month of application.

In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month. In this situation, the length of the eligibility periods remain the same (six months or one year, depending on the type of coverage).

A review is a redetermination of eligibility. Appropriate review forms must be used. If the recipient is no longer eligible, Advance Notices must be sent. If the review form is not received in a regional office by the end of the month in which Advance Notice Period ends, it is considered a reapplication.

1510 CATEGORICALLY NEEDY ELIGIBILITY PERIODS

Categorically Needy coverage begins on the first day of the month that the individual is eligible unless temporary coverage is being given. (See "45 Day Processing Standard", Section 1431.)

The review period for all Categorical coverage groups, Family-Related and SSI-Related, is twelve months.

1511 CHANGES WITHIN THE CATEGORICALLY NEEDY ELIGIBILITY PERIOD

Changes reported by recipients during the twelve month eligibility period must be reviewed by the Medical Assistance Eligibility Specialist to determine the effect of the change on the individual’s eligibility.

If the new information results in a change in the level of coverage, the Medical Assistance Specialist must give the recipient adequate and timely notice of the change of level or termination in coverage;

Certain individuals have a continuous period of eligibility even if changes occur. These groups are:

I. Newborns

If the newborn's mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible for the same level of coverage as the mother regardless of the newborn's income. The mother must be fully covered by Medicaid on the day of the baby's birth. In other words, if mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year as long as the mother maintains the home for the child. This means that the baby is eligible without regard to changes in family income or composition. The child is continuously eligible under this group for the one year unless s/he no longer resides with the mother, moves out of state or mail is returned as undeliverable.

II. Children under age 19

Children under the age of 19, including newborns, (through the end of the month of their 19th birthday) are continuously eligible for full benefits for twelve (12) months after eligibility is determined by application or review beginning with the month of application or review.

The child is continuously eligible without regard to changes in family income or composition.

The child is continuously eligible until the end of the twelve (12) months unless s/he reaches age 19, is no longer a state resident or mail is returned as undeliverable.

This provision applies to all categorically eligible children including those eligible for TANF or SSI/State Supplement benefits or as SSI-Related.

Medical coverage continues for twelve (12) months even if the SSI, State Supplement or TANF benefit ends.

When TANF or State Supplement benefits end before the twelve (12) month medical eligibility period, the child's coverage continues and a review is due for month twelve (12).

1511 cont.

The last TANF or State Supplement review is considered to be a review for Medicaid. The twelve (12) months of continuous coverage starts from that date.

The Medicaid review after an SSI closing is the start of a 12 month eligibility period.

EXAMPLE 1:
A TANF Review done in November, 2002, results in continuing eligibility. The next TANF review is done in May, 2003, and the family is over income for TANF. Medical coverage for the children extends through October, 2003.

EXAMPLE 2:
A child is eligible as SSI-related in December, 2002. The child is found to not meet the disability criteria in July, 2003. Medical coverage continues through November, 2003 when a review of eligibility is completed.

When individuals lose eligibility for TANF or SSI/State Supplement payments and a review for continued Medical Assistance is needed, existing information in the case record is used to determine continuing eligibility for Medicaid. If there is insufficient information in the case record to determine eligibility or a disability determination is necessary, coverage must be continued until ineligibility is determined. If a review form is necessary, it must be sent to the individual within ten days of the date of the receipt of the computer printout notification that TANF or SSI coverage has ended. Prospective eligibility must be based on the review information and the Family-Related or SSI-Related criteria. (See Sections 2000 and 3000.)

III. Pregnant women

Once granted, pregnant women are continuously eligible for 60 days beyond the date the pregnancy ends and through the last day of the month in which the 60th day falls.

1520 MEDICALLY NEEDY ELIGIBILITY PERIODS

All Medically Needy (MI) recipients have a six month deductible period. The only time the six month deductible period can be shortened is in situations when:

I. the individual, age 20, will turn 21 in less than six months;

II. the individual dies;

III. the individual becomes eligible for coverage in nursing care status;

IV. the individual voluntarily withdraws from the program. If the individual voluntarily withdraws and reapplies, new deductible periods (both retroactive and prospective) are established based on the new application. Some months of the retroactive coverage possible from the first application may not be included in the new retroactive period which is established with the reapplication.

Medically Needy coverage begins on the day of the month that the deductible is met. The individual may have some responsibility for bills for medical services incurred on that day. If there is no deductible or the deductible is met with uncoverable items, coverage begins on the first day of the month of eligibility.

Once the date of eligibility is established, unless there is a change in income which changes the deductible amount or the individual becomes ineligible for Medical Assistance, coverage continues to the end of the deductible period.

Although individuals who are eligible for Medically Needy coverage are in a deductible for 6 months, if their income is stable and is between the Categorically Needy income levels and the Protected Income Level (PIL), a complete review is necessary once every 12 months rather than once every 6 months. Any potential change in circumstances should be noted at the time of the review and a recall scheduled.

1521 CHANGES WITHIN THE MEDICALLY NEEDY ELIGIBILITY PERIOD

All changes reported by the recipient during the six month eligibility period must be reviewed by the Medical Assistance Eligibility Specialist to determine the effect of the change on the individual's eligibility.

If the new information results in a change in the level of coverage, the Medical Assistance Eligibility Specialist must:

I. give the recipient adequate and timely notice of the change of level or termination in coverage;

II. determine the effect of the new information on the amount of the deductible;

III. allow the individual to withdraw and reapply if the information would result in a change of coverage to Categorically Needy.

EXAMPLES:

A. The individual applies on January 16th and is in a $60 deductible from January through June. On February 2nd the individual meets her deductible. On March 2nd, she reports an increase in wages. As a result of the wage increase, her deductible for the January through June period is $90. Her Medically Needy coverage is ended and she is put into a deductible of $30 (the difference between the original deductible of $60, which she has met, and $90, the new deductible) for April through June.

B. The individual applies on January 16th and is in a $60 deductible. On March 2nd he reports a decrease in wages. As a result of the wage decrease, his deductible for January through June is revised from $60 to $30. The decreased wages actually entitle him to Categorically Needy coverage from the month of March on. He must be given the opportunity to withdraw the Medically Needy application and file a reapplication. He must also be informed that reapplying will change the dates of coverage and will affect the months of possible retroactive coverage.

1530 RETROACTIVE PERIOD

The individual does not have to be eligible in the month of application in order to be eligible for retroactive coverage.

Eligibility for retroactive coverage must be determined separately from prospective coverage. It is possible for an individual to be covered as Medically Needy (MI) during the retroactive period and Categorically Needy (MM) prospectively or vice versa.

The individual must meet basic eligibility requirements for any month during which coverage is received. For example, a person who turned age 65 in the month of application cannot be covered retroactively unless SSI-related disability criteria was met during the retroactive period.(For persons who are eligible for SSI payments based on a disabling condition, see Section 3130.)

The entire three month period may be covered if the individual is eligible for all three months. It is not possible to cover the third month prior to the application month without including the first and second months unless the individual is ineligible due to basic eligibility requirements or excess assets during the intervening months.

EXAMPLES:

I. The individual applies in August and has medical expenses incurred in May. There are no bills for June and July. The individual has a deductible of $10 per month. In order to cover the bills incurred in May, the deductible is $30, not $10. June and July could be covered with a deductible of $20 or July only with a deductible of $10, but coverage must be continuously retroactive from the application month.

II. The individual applies in March and incurred medical expenses in December, January and February. The person had assets of $1500 in December, $2500 in January and $700 in February. Bills incurred in the month of January cannot be covered by Medicaid as the assets exceeded the asset limit that month. The person's deductible for December and February are added together. The bills incurred in January for which the individual is still responsible can be used as non-covered items toward meeting the deductible. (See Section 5000).

The individual who has a deductible period may withdraw from the program and reapply for retroactive coverage. If an individual voluntarily withdraws, a new prospective period begins with the month of the new application and retroactive eligibility can be determined for up to three months prior to the month of the new application.

In determining eligibility for the retroactive period, income actually received during that period is used.

Individuals who are determined to be eligible for SSI benefits and who indicate on their SSI application that they have medical expenses for the three months prior to their application for SSI do not need to make a separate application for retroactive Medicaid coverage.

If the individual meets the non-financial criteria and the TANFor Food Stamp case folder contains enough information about the individual's financial situation to determine eligibility for the three month retroactive period, the individual will be sent a Medicaid card and notice of eligibility for Medicaid. If there is not sufficient information in the TANFor Food Stamp case folder or the individual is not a recipient of TANFor Food Stamps, the individual should be contacted in writing and verification of specific information requested. Due to the length of time involved in establishing SSI eligibility, especially if a disability decision is involved, requests for information should be reasonable and lenient.

Individuals who are determined to be eligible for SSI and who indicate on the application for SSI that they do not have medical expenses for the three months prior to their application for SSI will be sent a notice of denial for the three month period.

1540 RECALLS

If there is reason to believe the individual’s situation will change and it will affect eligibility, the Medical Assistance Eligibility Specialist may recall the case to look at specific eligibility factors rather than review the individual's entire situation.

1550 RESERVED

1560 UNFUNDED CHECKS

An unfunded or bounced check is considered non-payment of a premium.

Upon notice from State Treasury that a check has bounced, the household will be sent a notice of non-payment including the amount now due.

If no payment is received within 30 days of the 1st notice, a 2nd notice is sent.

If no payment is received, the penalty will take effect the month following the month in which the 2nd notice is sent as long as the client has received twelve (12) days advance notice.

1560 cont.

Example: The family is sent 2nd notice of non-payment on May 10th. No payment is received within twelve (12) days. The penalty starts in June 1st. If the notice was not sent until May 30, the penalty would take effect in July.

The penalty is a period of time during which the client cannot get coverage under the option for which there is a non-payment. How long this lasts depends on the coverage option involved.

For **Cub Care**, there is a month of ineligibility for each month of non-payment up to a maximum of 3 months.

NOTE: A family's 6 month enrollment period cannot be ended in order to impose this penalty. The penalty starts at the end of any current enrollment period.

In the example above, if the family's enrollment period was January through June, the penalty would take effect in July rather than May.

For **Transitional Medicaid** (TM), coverage under TM ends and cannot be reinstated for any remaining months in the TM period for which a bounced check is received unless overdue premiums are paid. Unpaid premiums from one period of TM does not affect eligibility for subsequent periods of TM.

For **Working Disabled**, coverage cannot continue after the end of the current or last enrollment period unless the unpaid premiums are paid.